Cardiology Practice Alternatives—Alignment vs. Independence

Comparing Practice Options Based on Facility and Non-Facility Billing Analysis

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INTRODUCTION

Physicians and hospital providers of healthcare are undergoing an unprecedented period of adjustment, with every component of their operations under scrutiny. This tedious inspection is from state and federal governments and commercial third-party payers, as well. From seasoned healthcare providers' perspectives, it seems that physicians and hospitals have become the "whipping boys" with pressures on costs and overall economics of healthcare. All the while, the consumers of healthcare in the United States continue (and have every right) to expect the highest quality of care possible.

Many providers are reevaluating their options regarding their practice structure for how best to respond to these dynamics. Cardiology, in particular, and cardiac care service providers supporting this specialty are facing unprecedented challenges. Cardiology physicians—interventional, diagnostic, invasive, electrophysiologists, interventional—that support this essential specialty are experiencing draconian challenges. These challenges relate to implausible reductions in reimbursement, especially payment for services that are performed in addition to professional services, the testing and diagnostics that support the specialty. And, especially, this relates to the reimbursement that private practicing physicians receive for such ancillary services. While hospitals have also experienced stress in the specialty of cardiology services; their reductions, particularly by Medicare/Medicaid, have been less significant (if at all) compared to private practices. But how long this will last is uncertain.

In considering billing scenarios that ultimately support the strategies of both private cardiology specialists and hospitals, this paper presents an objective view of what has happened (and may increasingly occur in the future) to cardiology billing. This report provides an overview of this situation in order to assist in the decision making for those practices considering integration or alignment options.

OVERVIEW

Since 2009, Medicare has reduced reimbursement for many cardiology tests. This has had a significant impact on private practice revenue, as many cardiologists have established diagnostic testing within their private practices in support of the care they provide. The reimbursement for these tests, a major portion of which is from Medicare, has historically contributed greatly toward supporting revenue and profit margins to the typical private cardiology practice. These cuts have

notably reduced those margins requiring most private practicing cardiologists to rely heavily on their professional fees to realize any margin.

An example of the reductions includes the Medicare allowable for global reimbursement for a transthoracic echocardiography with Doppler was reimbursed at $247.18 in 2009. Now, Medicare pays $222.64 for this service.[1] The Medicare allowable for other echocardiography services declined an average of $10 per test.

In addition, nuclear medicine services underwent codes changes in 2010. The Medicare allowable for nuclear medicine multiple studies declined from $445.63 to $353.49. Reimbursement for catheter procedures declined approximately $200 per procedure.

Regardless of the way these cuts are considered, they result in a collective reduction of from at least ***15%*** to ***25-30%*** per private practice.[1]

Non-Facility Based Billing for Ancillary Services

The following table provides an example of what a non-facility based cardiology practice could have expected to be reimbursed by Medicare in 2009 compared to the 2010 revised rates (based upon comparable volumes). This example assumes that the tests were performed in the private practice.

Table I -- Non-Facility Based Billing

	CPT Codes		Medicare Volume	2009 Practice Owned		2010 Practice Owned		Variance
				Global per Unit	Total	Global per Unit	Total	
	2009	2010						
Echo	93306		1,660	$247.18	$410,318.80	$222.64	$369,582.40	($40,736.40)
	93307		40	$163.57	$6,542.80	$143.77	$5,750.80	($792.00)
	93308		50	$103.28	$5,164.00	$96.48	$4,824.00	($340.00)
	93350		5	$197.89	$989.45	$190.54	$952.70	($36.75)
	93351		35	$237.29	$8,305.15	$226.87	$7,940.45	($364.70)
Total Echo			**1,790**		**$431,320.20**		**$389,050.35**	**($42,269.85)**
Nuclear	78464	78451	8	$252.53	$2,020.24	$207.65	$1,661.20	($359.04)
	78465	78452	1,590	$445.63	$708,551.70	$353.49	$562,049.10	($146,502.60)
Total Nuclear			**1,598**		**$710,571.94**		**$563,710.30**	**($146,861.64)**
Overall Total			**3,388**		**$1,141,892.14**		**$952,760.65**	**($189,131.49)**

Conclusions

Based upon the analysis in Table I with a volume of 3,388 tests, Medicare would expect a decrease of from $1,141,892 in 2009 to $952,760 in 2010. This represents a loss of revenue to the private practice of over *$189,000* or *16.6%*. Whatever profit was derived from these tests in 2009 would be virtually gone with this change.[2]

Facility Based Billing for Ancillary Services

If the private practice were converted to a hospital-owned entity and the appropriate requirements for facility based designation realized, the physicians would then bill for the professional fee for the test (essentially unchanged) and the technical component would be billed by the hospital under the hospital outpatient perspective payment system (HOPPS). The following table shows reimbursement for the physician's professional fees and the reimbursement to the hospital under HOPPS.

Table II - Facility Based Billing

	CPT Codes		Medicare Volume	2010 Hospital-Owned					Variance
				Prof. per Unit	Total Pro fees		APC per Unit	Total Facility	Total	
	2009	2010								
Echo	93306		1,660	$66.87	$111,004.20		$416.91	$692,070.60	$803,074.80	$433,492.40
	93307		40	$46.41	$1,856.40		$244.35	$9,774.00	$11,630.40	$5,879.60
	93308		50	$26.83	$1,341.50		$244.24	$12,212.00	$13,553.50	$8,729.50
	93350		5	$74.49	$372.45		$416.81	$2,084.05	$2,456.50	$1,503.80
	93351		35	$90.90	$3,181.50		$550.57	$19,269.95	$22,451.45	$14,511.00
Total Echo			**1,790**		**$117,756.05**			**$735,410.60**	**$853,166.65**	**$464,116.30**
Nuclear	78464	78451	8	$63.90	$511.20		$716.44	$5,731.52	$6,242.72	$4,581.52
	78465	78452	1,590	$75.55	$120,124.50		$716.65	$1,139,473.50	$1,259,598.00	$697,548.90
Total Nuclear			**1,598**		**$120,635.70**			**$1,145,205.02**	**$1,265,840.72**	**$702,130.42**
Overall Total			**3,388**		**$238,391.75**			**$1,880,615.62**	**$2,119,007.37**	**$1,166,246.72**

Conclusions

Based upon the volume assumptions noted in Table II, under facility-based billing, the 2010 Medicare professional fees would total over $238,000. The facility fees would total over $1.8 million with total projected revenues of $2,119,007. These totals represent an increase in projected revenue of *$1,166,246* or *122.4%*.

Facility Based Billing for Ambulatory Visits

Facility based billing will also impact ambulatory visit reimbursement but to a much lesser extent. Table III illustrates the projected increase in reimbursement for ambulatory services if a practice were to become facility based. The illustration projects E/M distribution based upon the national distribution percentages for cardiologists.[3]

Table III - Facility Based Billing Ambulatory Visits

	MEDICARE 2010			2009 CPT Code Volume	Provider Based Billing Medicare				
	Prof Facility	Pro Office	Facility	Medicare	Prof Office	Pro Facility	Facility	Total	Variance
New Patient Office Visits									
99201	$23.53	$36.55	$54.20	2	$73.10	$47.06	$108.40	$155.46	$82.36
99202	$45.67	$63.36	$65.21	7	$443.52	$319.69	$456.47	$776.16	$332.64
99203	$68.78	$91.81	$83.40	39	$3,580.59	$2,682.42	$3,252.60	$5,935.02	$2,354.43
99204	$116.26	$142.63	$106.16	92	$13,121.96	$10,695.92	$9,766.72	$20,462.64	$7,340.68
99205	$150.81	$179.51	$156.77	48	$8,616.48	$7,238.88	$7,524.96	$14,763.84	$6,147.36
				188	**$25,835.65**	**$20,983.97**	**$21,109.15**	**$42,093.12**	**$16,257.47**
Established Patients Office Visits									
99211	$8.54	$17.89	$54.20	1,401	$25,063.89	$11,964.54	$75,934.20	$87,898.74	$62,834.85
99212	$23.20	$36.55	$65.21	407	$14,875.85	$9,442.40	$26,540.47	$35,982.87	$21,107.02
99213	$45.85	$61.87	$65.21	3,747	$231,826.89	$171,799.95	$244,341.87	$416,141.82	$184,314.93
99214	$70.80	$92.83	$83.40	3,616	$335,673.28	$256,012.80	$301,574.40	$557,587.20	$221,913.92
99215	$99.89	$125.26	$106.16	380	$47,598.80	$37,958.20	$40,340.80	$78,299.00	$30,700.20
				9,551	**$655,038.71**	**$487,177.89**	**$688,731.74**	**$1,175,909.63**	**$520,870.92**
				9,739	**$680,874.36**	**$508,161.86**	**$709,840.89**	**$1,218,002.75**	**$537,128.39**

Conclusions

Based upon the data in Table III, a projected increase in reimbursement of *$537,000* or *78%* would result in comparison to office space billing if a practice were to become facility based.

SUMMARY

The above analysis is a representative example of a typical practice in the Southeast. It provides a clear picture of the impact of the reimbursement changes, particularly as it affects private practices, which have historically realized a significant portion of their total revenue from ancillary (i.e., essentially diagnostic testing) services. These tests are and will continue to be needed as they provide the cardiologists with the necessary tools to diagnose and to treat the cardiac patient. The examples go on to illustrate the significant improved

reimbursement that can still be gained through HOPPS rates, assuming the practice becomes facility based (hospital owned/operated and presented as such). Clearly, the ability to bill both ancillary services (e.g., echocardiograms, nuclear studies, vascular studies, catheterization procedures, etc.) and ambulatory visits (i.e., evaluation and management, plus private cardiology procedural codes) under facility based billing, utilizing hospital reimbursement rates results in significantly greater reimbursement.

Consequently, cardiology is the single most prominent specialty working toward alignment between hospitals and physicians. Private cardiology groups cannot offset the loss in these ancillary revenues by merely doing more work, seeing more patients, and billing more professional fees. There are simply not enough hours in the day (and perhaps not even enough patients) for the typical private practicing cardiologist to make up this difference.

While many private practicing cardiologists would prefer to remain independent, they realize the immediate opportunity to respond to these cuts, especially from Medicare (likely many private insurers soon follow with comparable reductions) is to develop an alignment strategy with a hospital partner.

There are many alignment strategies and the alignment models are numerous; the fact is that most cardiologists must become knowledgeable of these models and obtain representation/assistance to help them navigate through their options.[4] The window of opportunity exists today, but will also close as industry benchmarks and survey data begin to catch up with the significantly lowering revenue and compensation totals for the cardiac care specialists. When these reductions become reflective of industry surveys' benchmark data, independent fair market value and commercially reasonable opinions rendered to support such compensation when cardiologists align with hospitals must reflect the lower payment totals.

How to respond to the need for cardiac care services and be assured that high quality cardiology specialists will be available to provide the care needed is a continuing struggle. Hospitals are taking charge of this situation by aligning with cardiologists, and cardiologists are working diligently to partner with hospitals in order to address the economic strain. How long the opportunity will be as compelling as the need is today is hard to determine. If Medicare inflicts further reductions, especially if applied toward hospital reimbursement, it will become very difficult for cardiologists in the U. S. to perform their services with the level of expertise required and still be compensated acceptably, consistent with their training and responsibility.

For more information concerning cardiology strategies and specific initiatives discussed in this report, contact Coker Group's president/CEO, Max Reiboldt, CPA, at 678.832.2007, mreiboldt@cokergroup.com.

NOTES

[1] Medicare rates are adjusted geographically, based upon strategic growth rate (SGR) criteria. The rates quoted are specific to a Coker client based in the Southeast. The impact of the rates is comparable regardless of where the cardiology practice is located.

[2] Costs to support these services have not gone down. Thus, the reduction in reimbursement based upon some of the average practices' payer mix of Medicare being at or close to 50% are inarguably devastating.

[3] For purposes of this illustration, we have projected evaluation and management code distributions based upon the national distribution percentages for cardiologists. Refer to Medicare and *E/M Bell Curve Data Book* (Gaithersburg, MD, UCG/Decision Health, 2009).

[4] Contact Coker's president/CEO, Max Reiboldt, CPA, at 678.832.2007 or via email at mreiboldt@cokergroup.com for more information including specific examples regarding cardiac care alignment models.